Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN3410ESR	A. BUILDING _____ B. WING _____	03/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN SIERRA DIALYSIS CTR	1500 E SECOND STREET SUITE 101 RENO, NV 89502

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1 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of the complaint survey conducted at your facility on 2/13/09 through 3/20/09. This survey was conducted in accordance with Chapter 449, Facilities for Treatment of Irreversible Renal Disease, adopted by the Board of Health August 1, 2001. Complaint #NV00020987 was substantiated. See Tags 204 and 206. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	1 000		
1 204 SS=D	449.540 Provision of Services 6. A facility shall report each of the following events to the bureau within 7 days after the event occurs: (a) Each accident or incident concerning a patient of the facility that: (1) Occurs during dialysis treatment of the patient; and (2) Results in the death of the patient or requires the admission of the patient to a hospital overnight. This Regulation is not met as evidenced by: Based on record review, occurrence report review, facility policy review, and staff interviews, the facility failed to report an incident that occurred during a dialysis treatment that resulted in an admission to the hospital for 1 of 1 patients. (#1)	1 204		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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1 204	Continued From page 1 Findings include: Patient #1 began dialyzing at the facility in September 2008. The 81 year patient was dialyzed three times a week for two and one-half hours at each treatment. She was dialyzing via a central venous catheter (CVC). Her chronic kidney disease was due to hypertension and diabetes. During her dialysis on 2/05/09, approximately one hour after beginning her treatment, it was documented in the progress details that staff noticed that Patient #1 was "unresponsive." She was placed in a Trendelenburg (head lowered) position and given saline. Cardiopulmonary resuscitation (CPR) was started. At some point, it was noticed that the dialysis tubing to her CVC had become disconnected and a blood spill was on the floor. The blood pump was stopped and 911 was called. Patient #1 was transported to the emergency room where emergency procedures were instituted and she was placed on life support. After several days with a poor response, the family elected to discontinue life support and the patient expired shortly afterwards. When the facility Administrator was asked during an interview on 2/13/09, about the failure to report the event, he disclosed that the Administrator, who witnessed the event, did not think it was reportable because it was a "witnessed code." Review of the facility policy titled "Incident Reports" (Policy 18) with an effective date of 01/15/07 revealed that "An incident report must be completed for any and all unusual occurrences involving patients, employees,	1 204		

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1 204	Continued From page 2 visitors, or clinic property within 24 hours of the occurrence." The patient incidents included "Death at the facility during TX or incidence that requires overnight hospitalization." The policy further read that "The State Department of Health shall be notified within seven days." Severity 2 Scope 1	1 204		
1 206 SS=G	449.5405 Provision of Services 1. In addition to the requirements set forth in NRS 449.700 <http://www.leg.state.nv.us/NRS/NRS-449.html> to 449.730 <http://www.leg.state.nv.us/NRS/NRS-449.html>, inclusive, each facility shall adopt and comply with a policy which ensures that each patient of the facility is: (a) Treated with respect, dignity and complete recognition of the individuality and personal requirements of the patient; (b) Provided with sufficient privacy during treatment to ensure that any unwarranted exposure of the patient does not occur and to ensure confidentiality of the clinical record of that patient; (c) Provided with a safe and comfortable environment for receiving any treatment provided by the facility; (d) Provided with information concerning his treatment in a manner which ensures that the patient or the legal representative of the patient understands that information; (e) Informed by a physician of the medical status of the patient; (f) Informed about all modalities and settings for the treatment of end-stage renal disease; (g) Informed about and participates in, if requested by the patient, each aspect of care,	1 206		

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1 206	Continued From page 3 including, without limitation, the right to refuse treatment and the medical consequences of refusing that treatment; (h) Aware of any services that are available to the patient at the facility and the charges for those services; and (i) Informed about any reuse of dialysis supplies by the facility, including hemodialyzers. If any brochures or other printed materials are used to describe the facility or any services provided by the facility, the facility shall ensure that the brochures or other printed materials include a statement specifying the policy of the facility concerning the reuse of those supplies. This Regulation is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a safe environment during treatment by failure to monitor the dialysis access site for 1 of 1 patients. (#1) Findings include: Patient #1 began dialyzing at the facility in September 2008. The 81 year patient was dialyzed three times a week for two and one-half hours at each treatment. She was dialyzing via a central venous catheter (CVC). Her chronic kidney disease was due to hypertension and diabetes. Documentation in the Progress Details by a staff nurse dated 2/5/09, read that it was "noticed that the patient became non responsive, patient was put in Trendelenburg position, and saline opened up, just then noticed that Permacath line became disconnected and blood spilled on floor."	1 206		

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1 206	Continued From page 4 In a telephone interview with the staff nurse at 1:00 PM on 2/13/09, he indicated that the line became disconnected and that the blood spill was under the chair. He estimated the spill was approximately one unit of blood (250 cc's). The patient care technician caring for Patient #1 was interviewed via telephone on 2/19/09 at 1:35 PM. She disclosed that the line to the tubing was unattached at the time of the event. When staff responded to the patient, there was noticeable blood on the patient's pillow and later, blood was found in the creases of the chair. She also revealed that prior to the occurrence, the patient was covered with blankets and that the central venous catheter (CVC) access was not visible to the staff. On 2/25/09, a second interview was conducted with the patient care technician. At the second interview she confirmed that the CVC was not visible to staff; the patient was covered with blankets. She also disclosed that when it was discovered that the line had become disconnected, the line was pointing downward. In a telephone interview with Patient #1's daughter on 3/11/09 at 3:00 PM, she stated that, on the days that she brought her mother into dialysis, she always covered her mother with as many as three blankets. The blankets would be up to her chin. The daughter stated that the dialysis staff never mentioned to her or her mother that the CVC needed to be visible to staff at all times for the patient's safety. The patient's daughter also revealed in the telephone interview that the facility did not return one of the blankets and her mother's pillow following the event. When she asked why she did not receive the items, the staff told her they were disposed of	1 206		

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1 206	Continued From page 5 because they were so covered with blood. Review of the ambulance services report disclosed that, upon arrival at the dialysis center, Patient #1 was lying supine on the floor unconscious and unresponsive. A pool of blood was next to her upper body. The report also documented that staff at the dialysis unit stated that "tubing came off her central line and that she bled out a lot of blood before they noticed." Review of a Nephrology Consultation report done in the hospital and dated 2/5/09, revealed severe blood loss due to disconnection of the Permacath with a developing asystolic cardiopulmonary arrest. Review of the patient record at the facility revealed that, two days prior to the event, laboratory results at the facility showed Patient #1's hemoglobin was 14. Her initial laboratory reports at the hospital after the event documented a hemoglobin of 8.5. A local nephrologist estimated that it would take a blood loss of approximately six pints or 3000 cc's to cause such a drop in the patient's hemoglobin. The average blood volume of a adult is approximately five liters or 5000 cc's (Volume of Blood in a Human edited by Glenn Elert) which would indicate that the patient had loss more than 50% of her total blood volume. Hypovolemic shock can be caused by depletion of blood volume by blood loss. Reduction in blood volume in return leads to reduced cardiac output and collapse. (Shock by Dr. Surajit Bhattacharya, MS, M.Ch. FICS) In a telephone interview with a technician at the manufacturing company of the dialysis machine, on 2/26/09 at 11:15 AM, it was verified that the	1 206		

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1 206	Continued From page 6 Blood Flow Rate (BFR) is the preset constant speed used to push the blood through the dialyzer and back into your body. The BFR is measured in milliliters (ml) per minute. A ml is equal to a cc. Review of the Hemodialysis Runsheet for 2/5/09, the day of the event, disclosed that the BFR was set at 357 to 362. That would indicate that 357 to 362 cc's of the Patient #1's blood was going through the dialysis machine each minute. When the line became detached, it would have taken the patient approximately eight and one-half minutes to have lost 3000 cc's or the suspected blood loss. Review of the facility's Occurrence Report revealed that the patient had suffered a cardiac arrest with the severity of the result as Major. The form indicated that the report had been reviewed by the department head and that "Action/Follow-Up" was needed. When the Administrator was asked for the follow-up, he indicated that one had not been done yet. This was eight days after the occurrence. Later, after the complaint investigation had been initiated, a statement was submitted that the occurrence had been investigated and that it was found that the "blood lines apparently became disconnected during the clinical response." There was no supporting data submitted with the conclusion. Severity 3 Scope 1	1 206		